TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Arlington

Respondent Name
Technology Insurance Co

MFDR Tracking Number
M4-16-3406-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is $4,267.94, minus their payment of $1,973.78 there is still an outstanding balance of $2,294.16."

Amount in Dispute: $2,294.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent paid a total of $1,973.96 for the total outpatient admission that occurred on 7/23/15. Payment was calculated according to the APC rate plus a markup. No additional monies are owed to Requestor.

Response Submitted by: Downs & Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2015	Outpatient Hospital Services	$2,294.16	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier. Combination provided on the same day according to the NCCI or workers' compensation state regulations /fee-schedule requirements
- 435 – Per NCCI edits the value of this procedure is included in the value of the comprehensive procedure
- 18 – Exact duplicate claim/service

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services which are:

1. **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,

   To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.
2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
4. **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Issues

1. What is the applicable fee pertaining to reimbursement?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

   The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement

formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent;

The services in dispute are reimbursed based on the following:

Submitted code	Status Indicator	APC	Subject to Composite	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index or 0.9512	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
70450	Q3	n/a	Yes, 8006	$528.56	$528.56 x 60% = $317.14	$317.14 x 0.9512 = $301.66	$528.56 x 40% = $211.42	$301.66 + $211.42 = $513.08	$513.08 x 200% = $1,026.16
72125	Q3	n/a	As above						
74177	Q3	n/a	As above						
71260	Q3	n/a	As above						
99284	V	615	No	$333.80	$333.80 x 60% = $200.28	$200.28 x 0.9512 = $190.51	$333.80 x 40% = $133.52	$190.51 + $133.52 = $324.03	$324.03 x 200% = $648.06
								Total	$1,674.22

2. The remaining codes were denied with adjustment/reason code(s) 618 – "The value of this procedure is packaged into the payment of other services performed on the same date of service," 630 – "This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC," 236 – "This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier. Combination provided on the same day according to the NCCI or workers' compensation state regulations /fee-schedule requirements," and 435 – "Per NCCI edits the value of this procedure is included in the value of the comprehensive procedure."

28 Texas Administrative Code §134.403 (d) states in pertinent part,

> For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…

Review of the remaining codes in dispute finds the following:

- Procedure code 36415 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80048 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85025 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 73030 has status indicator Q1 denoting STVX-packaged codes; payment for this service is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such

procedures are reported for the same date. Code 99284 has a status indicator of V. No additional payment is due.

- Procedure code 73090 has status indicator Q1 denoting STVX-packaged codes; payment for this service is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. Code 99284 has a status indicator of V. No additional payment is due.
- Per National Correct Coding Initiatives, procedure code 96374 may not be reported with procedure code 99284 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J2270 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code Q9967 has status indicator N denoting packaged items and services with no separate APC payment.

Pursuant to Rule 134.403 (d) the carrier's denial/reduction is supported.

3. The maximum allowable reimbursement for the eligible service is $1,674.22. The carrier paid $1,973.98. No additional payment is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 4, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.